TEXAS DEPARTMENT OF LICENSING & REGULATION

P.O. Box 12157 • Austin, Texas 78711-2157

www.tdlr.texas.gov

PODIATRIC MEDICAL ASSISTANT RADIOLOGICAL TECHNICIAN INSTRUCTIONS

DOCUMENTS SUBMITTED WITH YOUR APPLICATION WILL NOT BE RETURNED. KEEP A COPY OF YOUR COMPLETED APPLICATION, ALL ATTACHMENTS, AND YOUR CHECK OR MONEY ORDER.

1. NAME – Provide your legal name in the spaces provided. (Last Name, First Name, Middle Name, Suffix) Examples of a suffix include Jr., Sr., and II. (Mr. is not a suffix.)
2. HOME ADDRESS – Provide your current home address. This is the address where we will send you mail. This address can be a post office box. You can add the zip plus-4 to help the postal service deliver mail more efficiently and accurately.
3. PHONE NUMBER – Provide a telephone number, including the area code, where we can reach you during the day. This may be your office phone number where we can leave a message.
4. SOCIAL SECURITY NUMBER – Social security number disclosure is required by Section 231.302(c)(1) of the Texas Family Code in order to obtain a license. Your social security number is subject to disclosure to an agency authorized to assist in the collection of child support payments. For more information regarding child support payments, visit the ***Texas Attorney General*** website or call (512) 460-6000 or (800) 252-8014.
5. DATE OF BIRTH – Provide your birthdate.
6. SUPERVISING PODIATRIC PHYSICIANS – List all supervising podiatric physicians and their locations. Attach additional pages if needed.
7. ACKNOWLEDGMENT – Carefully read the statement before dating and signing your application.

REQUIREMENTS FOR PODIATRIC MEDICAL ASSISTANT RADIOLOGICAL TECHNICIAN

☐ Complete form and return to Texas Department of Licensing and Regulation

☐ Registration fee of $25.00 (Application will be returned if fee not included)

☐ Proof of successful completion of training (copy of certificate) must accompany this form in order to be processed. Mandatory training is set out 16 Texas Administrative Code, §130.53 (relating to Alternate Training Requirements for "Podiatric Medical Assistants").

SEND YOUR COMPLETED APPLICATION AND REQUIRED DOCUMENTS TO:

TDLR
P.O. Box 12157
Austin, TX 78711-2157

Documents submitted with your application will not be returned. Keep a copy of your completed application, all attachments, and your check or money order. Do not send cash.

For additional information and questions, please visit the ***TDLR website***. You may request assistance or submit required attachments via ***TDLR webform***. You may contact Customer Service Representatives by calling (800) 803-9202 [in state only], or (512) 463-6599; Relay Texas - TDD: (800) 735-2989. Customer Service Representatives are available Monday through Friday 7:00 a.m. until 6:00 p.m. Central Time (excluding holidays).

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PODIATRIC MEDICAL ASSISTANT RADIOLOGICAL TECHNICIAN REGISTRATION

REGISTRATION FEE: $25.00 (FEE IS NON-REFUNDABLE)

This completed form must be accompanied by all required documents and the registration fee.

Proof of successful completion of the Podiatric Medical Assistant training (copy of certificate) must accompany this form.

1. Name:

Last, First, Middle Name, Suffix (Jr., Sr., III)

2. Home Address:

Number, Street Name/Apartment Number, City, State, Zip Code

3. Phone Number:	**4. Social Security Number:**	**5. Date of Birth:**
(Area Code) Phone Number	See Instruction Sheet for Disclosure Information	Month/Day/Year

6. SUPERVISING PODIATRIC PHYSICIANS

Podiatric Medical Assistant must perform radiological procedures only under the supervision of a podiatric physician physically present on the premises. List all supervising podiatric physicians and their location. Attach additional pages if needed.

Physicians Name: Last, First, Middle Name	**DPM License #:**
Name of Facility/Location:	**Phone Number:** (Area Code) Phone Number
Physical Address: Number, Street Name/Suite, City, State, Zip Code	**Date of Employment:** Month/Day/Year
Physicians Name: Last, First, Middle Name	**DPM License #:**
Name of Facility/Location:	**Phone Number:** (Area Code) Phone Number
Physical Address: Number, Street Name/Suite, City, State, Zip Code	**Date of Employment:** Month/Day/Year
Physicians Name: Last, First, Middle Name	**DPM License #:**
Name of Facility/Location:	**Phone Number:** (Area Code) Phone Number
Physical Address: Number, Street Name/Suite, City, State, Zip Code	**Date of Employment:** Month/Day/Year

Physicians Name:	**DPM License #:**
Last, First, Middle Name	
Name of Facility/Location:	**Phone Number:**
	(Area Code) Phone Number
Physical Address:	**Date of Employment:**
Number, Street Name/Suite, City, State, Zip Code	Month/Day/Year

7. ACKNOWLEDGMENT

By signing and submitting this registration, I certify that the information on this and any attached form is true and correct. I understand that providing false information on this application may result in revocation and/or denial of the registration I am requesting and the imposition of administrative penalties and sanctions.

Signature of Applicant

Date Signed

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